DMHMRS 02-03
attachment I

DEPARTMENT FOR MENTAL HEALTH AND MENTAL RETARDATION
REQUEST FOR AMENDMENT OF HEALTH INFORMATION

DATE_____

NAME_____

BIRTHDATE_____MEDICAL RECORD #_____

ADDRESS_____

I understand the Department may or may not add an addendum to my medical record and will not alter the original documentation of the medical record. This request for an addendum will be made part of my permanent medical record and any amended information to individuals or organizations identified as having relied on the content of my medical record.

Describe the information you want amended (e.g., lab results, physician notes)_____
_____

Date(s) of information to be amended (e.g., date of office visit, treatment)_____

Reason for making this request_____

What would you like to amend to the record_____
_____

Do you know of anyone who may have received or relied on the information in question (e.g., physician, pharmacist or other health care provider? □ yes □ no

If yes, please specify the name(s) and address(es)_____
_____
_____

Signature_____Date_____

FOR DMHMRS USE ONLY
Amendment has been: □ accepted □ denied
If denied, check reason for denial:
- □ Health information was not created by this organization
- □ Health information is accurate and complete
- □ Health information is not part of the individual's designated record set
- □ Other_____

Reviewers Signature_____Title_____
□ Denial letter sent Date_____